

State of California
MH 2180(1/07)

Department of Mental Health

MEDI-CAL (M/C) CERTIFICATION AND TRANSMITTAL

NPI# 1538324199

COUNTY CODE: 31

Part A: Provide the following information:COUNTY SUBMITTING FORM: Placer

TYPE OF TRANSACTION (Check all that apply) ☐ Activate ☐ Terminate ☒ Change ☒ Re-Cert
 If change, indicate one or more types: ☐ Name ☒ Address ☐ Mode/SF ☐ Effective Date

PROVIDER NUMBER: 31AVPROVIDER NAME: Turning Point Community ProgramsPROVIDER ADDRESS: 120 Ascot Drive Suite DPROVIDER ZIP CODE: 95678PROVIDER CITY: RosevilleM/C ACTIVATION DATE: _____ M/C TERMINATION DATE: _____ M/C RECERT DATE: 3-28-12IF CHANGE, EFFECTIVE DATE OF CHANGE: 2-22-12

Per the MHP Contract, the M/C activation date cannot be earlier than the latest date of the following dates:

1) Date the site was operational: 2-22-122) Date of the fire clearance: 2-22-123) Date the provider requested certification: 2-22-12In addition, the onsite review must be within six months of these dates. Date of onsite review: 3-28-12Is the county submitting this form, the host county? ☒ yes ☐ no If no, name host county? _____

Indicate services Revenue/Procedure Code (CR/DC Mode, Service Function)

<input type="checkbox"/> (07) General Hospital	0100 (05/10)	0101 (05/19)	<input type="checkbox"/> Non-Hospital PHF	H2013 (05/20)
<input type="checkbox"/> (08) Psych Hosp Age (< 21)	0100 (05/10)	0101 (05/19)	<input type="checkbox"/> Crisis Residential	H0018 (05/40)
<input type="checkbox"/> (09) Psych Hosp Age (> 64)	0100 (05/10)	0101 (05/19)	<input type="checkbox"/> Adult Residential	H0019 (05/65)

For Residential - How many beds? _____

Check only one Mode (either 12 or 18):

☐ (12) Hospital Outpatient☒ (18) Non-Hospital Outpatient

Indicate services Procedure Code (CR/DC Mode, Service Function)

(Check all that apply)

<input type="checkbox"/> Crisis Stabilization ER	S9484 (10/20)	<input type="checkbox"/> Crisis Stabilization UC	S9484 (10/26)
<input type="checkbox"/> Day TX Intensive Half Day	H2012 (10/81)	<input type="checkbox"/> Day TX Intensive Full Day	H2012 (10/85)
<input type="checkbox"/> Day Rehab. Half Day	H2012 (10/91)	<input type="checkbox"/> Day Rehab. Full Day	H2012 (10/95)
<input checked="" type="checkbox"/> Case Manage./Brokerage	T1017 (15/01)	<input checked="" type="checkbox"/> MHS H2015 (15/30)	<input type="checkbox"/> TBS H2019 (15/58)
<input checked="" type="checkbox"/> Medication Support	H2010 (15/60)	<input checked="" type="checkbox"/> Crisis Intervention H2011 (15/70)	

The above named provider is certified by this agency to participate in the Short-Doyle/Medi-Cal program. I attest that the above named provider site complies with requirements of the CCR, Title 9, Sections 1810.435-436, the terms of the contract between the MHP and the Department.

Derek Holley

Print name of person completing form.

County Fax: (530) 886-1888

Phone: (530) 886-1860

Date: 4/2/2012

Authorized Signature.

Check below to indicate person signing.

☒ County Mental Health Director or Designee☐ Medi-Cal Oversight

To be submitted to Medi-Cal Oversight for signature below.

Part B: Medi-Cal Oversight Approval to Transmit Data to DHS

Claudia Poole

Medi-Cal Oversight

FAXED
4/10/12

4/9/12